

**PENFIELD HIGH SCHOOL  
HEALTH OFFICE  
Permission to Self-Carry Medication on Field Trips  
Phone: 249-6780, 249-6721, 249-6808  
Fax: 249-6810**

Students may carry medications and self-administer **ONLY** if the following conditions have been satisfied:

1. This form has been completed in full and signed by physician and parent
2. The student has been educated in regard to responsible use of this medication
3. School nurse finds the student to be responsible
4. If irresponsible use is noted, the privilege will be rescinded immediately

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Last) (First) (MI)

**Medication #1** \_\_\_\_\_

Dosage \_\_\_\_\_ Time to be given \_\_\_\_\_ AM \_\_\_\_\_ PM

Reason to be given \_\_\_\_\_  
\_\_\_\_\_

**Medication #2** \_\_\_\_\_

Dosage \_\_\_\_\_ Time to be given \_\_\_\_\_ AM \_\_\_\_\_ PM

Reason to be given \_\_\_\_\_  
\_\_\_\_\_

**Medication #3** \_\_\_\_\_

Dosage \_\_\_\_\_ Time to be given \_\_\_\_\_ AM \_\_\_\_\_ PM

Reason to be given \_\_\_\_\_  
\_\_\_\_\_

**Comments** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Student appears mature and responsible. Self-medication is part of a therapeutic plan.

\_\_\_\_\_ Student was instructed in proper usage, storage and dosing of the medicine and appears self-directed to parent, physician.

\_\_\_\_\_ Student has my permission to carry no more than the required amount of medication to last for the duration of the trip.

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date and Phone Number

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date and Phone Number